ABSTRACT

Minority women identify finances and maintaining cultural values as their most commonly experienced stressors at home and in the workplace.

A before and after study of ethnic minority women in focus group sessions led by a trained ethnic minority facilitator examined how social and workplace supports, or lack thereof, impact on the individuals' ability to manage daily life. Creative, effective solutions to stressors were identified by the participants. Outcomes were evaluated in terms of the impact of changes on the participants' coping styles in family and work life.

Results indicate that a large percentage of women in this study felt discriminated against based on their culture/race, however, this perceived discrimination decreased after the focus groups. The predominant stress management techniques were prayer and music. Family support was the most influential factor in decreasing stress. The family is a major source of support for the working women, acting as a buffer to workplace pressures.

ABRÉGÉ

Les femmes des minorités visibles identifient les difficultés financières et le maintien des valeurs culturelles comme leurs deux principaux facteurs de stress, tant au foyer qu'au travail.

Une étude des femmes des minorités visibles, faite avant et après des réunions de groupes types animées par un spécialiste du milieu, a examiné l'impact de la disponibilité ou du manque d'appuis sociaux et au travail sur l'aptitude de ces femmes à gérer leur quotidien. Les participantes ont proposé des solutions imaginatives et efficaces pour contrer ces facteurs de stress. Les résultats ont été évalués en termes d'impact des changements subséquents sur les aptitudes des participantes à faire face au sein de la famille et au travail.

Les résultats indiquent qu'un pourcentage élevé des participantes à cette étude avaient le sentiment de faire l'objet de discriminations basées sur leur culture/ethnie; toutefois, cette perception diminuait après les réunions des groupes types. Les principales techniques de gestion du stress étaient la prière et la musique. Le soutien familial était le plus important facteur de diminution du stress. La famille représente une grande source d'appui pour les femmes qui travaillent; ce soutien agit comme un tampon de protection contre les pressions découlant du travail professionnel.

Management of Family and Workplace Stress Experienced by Women of Colour from Various Cultural Backgrounds

Basanti Majumdar, PhD, Shelina Ladak, BA

A study of immigrant, refugee and racial minority women by the Women's Health Bureau,¹ identified mental health and stress-related issues as major health concerns for these target groups. Focus group interviews identified key stressors as attitude toward lower wages, lack of support (child care, transportation, family), cultural differences, discrimination, lack of up-to-date training, language barriers and unemployment. It was recommended in the outcomes that effective stress management programs be established to assist immigrant, refugee and racial minority women.

Using small group discussion among immigrant women, this study examined the clinical manifestations and management of stress and aimed to increase coping strategies. It was hoped that these women would gain greater control over their lives and thus become empowered.

Women account for at least 45% of the paid labour force across Canada.² The number of hours necessary for a family to meet its basic needs is now 65-80 hours per week, making the presence of women in the workforce imperative.³ Paid employment would appear to be a solution to both ethnic and mainstream women's poverty and associated ill-health.^{1,4} This employment outside of the home can create new sources of stress, an area which has received little attention with regards to ethnic minority women, especially as the

immigrant population has shifted to include more people of Eastern or African culture.⁵

Women in general perform a disproportionate share of domestic chores even while working outside the home, which may actually increase their distress.^{2,5} In addition to this stress, women of ethnic minorities experience psychological adaptation due to cultural conflict as they adjust to resettlement conditions, occupational and financial difficulties, loss of status, and reduced social support.⁶⁻⁸ This lack of social support has also been linked to increases in mental illness and ill-health, placing these women at high risk for depression.^{6,9-16}

Women attributed their health problems to many sources including rigid schedules, feelings of worthlessness on the job or at home, and a lack of support from employers and family.¹⁷ Women are being physically and mentally abused by the competing demands of their multiple roles as caregiver, housekeeper and breadwinner.¹⁸

As the number of women in the workforce increases, so does their exposure to these unique stressors:¹⁹ open racial/sexual harassment; isolation/loneliness; and noisy, unclean, dangerous working environments.¹⁸ Although the impact of ethnicity in this area has been only minimally studied, data show that women of high visible minority experience increased harassment on the job.¹⁹⁻²¹

The means by which these women manage stress, which is often culturally determined, was of interest to the researchers.²² The need for further research became apparent as the literature review revealed that this population was under duress from many sources. In helping these women identify their unique stressors and the clin-

This study was funded by the Ontario Ministry of Health, Women's Health Promotion, and the McMaster Research Centre for the Promotion of Women's Health.

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ical manifestations thereof, it was hoped that new methods of coping might be devised, allowing control to be regained and the women to be empowered.

METHOD

A descriptive pretest/post-test study was carried out with 67 women of diverse ethnicity using the focus group method. A focus group is composed of 6 to 12 individuals who are similar in some way and come together to discuss an issue of interest to research. The dynamic of group interactions is used to stimulate the thinking and verbal contributions of the participants, providing the researcher with detailed perspectives that could not be obtained through other methodological strategies.²³⁻³⁰ Facilitators guided the group discussion using the Cycle of Stress Process (Figure 1) and allowing participants to start anywhere within the cycle. The Train-the-Trainer technique was used to educate the facilitators in group process, stress and stress management techniques.

The facilitators were recruited from ethnic populations by advertising in the newspaper, on the radio, and in multicultural organizations. They received 16 hours of training. Each facilitator recruited volunteer participants, a maximum of 10 per group, from their respective cultural/religious community and provided a culturally sensitive educational program in the mother tongue of the group. Therefore congruency existed among all group members regarding their beliefs, values, culture and language, which promoted group cohesion.

The focus groups met for a total of 12 hours with the time divided so that there was at least one month between the first and last meetings. The content of the focus groups included: stress in the workplace and family, identifying stress and what to do about it, what are the signs and symptoms of stress, what do we do about it, how do we resolve it, where do we go for advocacy, how can we be more powerful, and how to implement change. Participants were encouraged to express their feelings and values related to family and workplace stress.

Interview guide

While numerous instruments exist to measure stress,³¹⁻³⁵ only one has been developed and validated specifically for immigrant, refugee, and racial minority women.³⁶ To establish content validity, the questionnaire was administered to 18 facilitators to ensure that terminology and expressions were culturally appropriate. A modified version of the questionnaire was used to interview women accustomed to the verbal tradition. Based on the facilitators' feedback, the format was restructured ($r=0.72$). The interview guide was translated into the Lao and Arabic languages and retranslated back into English. Content reliability was established. Inter- and intra-rater reliability ($r=0.82$ and $r=0.72$ respectively) and validity of the translated interview guide was established.

RESULTS

Sixty-seven focus group participants completed the interview guide at T_1 and T_2 . Sixty-two percent of the women were between the ages of 30 to 49 years. Thirteen percent earned less than \$500 monthly and 15% earned between \$501-\$1000 per month. At T_1 , 54% of participants were employed which decreased to 52% at T_2 . Although a large percentage of women were employed, 60% earned below the nationally recognized poverty line.

Participants were from Africa (30%) and the Middle East (24%), with Islam the predominant religion. English was identified as the first language spoken by 34% of participants.

The physical and mental health of the participants remained constant during the study with over 70% rating their health as good. Ninety-seven percent of participants

TABLE I
Items Identified as Sources of Stress (n=67)

Areas of Stress	T ₁ (%)	T ₂ (%)	χ^2	p
Finances	58	52	1.14	0.28
Income	57	42	6.25	0.01
Family	54	61	1.32	0.25
Housework	43	51	1.19	0.27
Discrimination	40	31	3.60	0.05
Parenting	40	40	0.00	1.00
Studying	40	40	0.00	1.00
No Advancement Opportunity	37	31	0.80	0.37
Workplace	36	36	0.00	1.00
Isolation	34	42	1.67	0.19
Unemployment	33	33	0.00	1.00
Child Illness	31	39	2.27	0.13
Access to Education	31	28	0.33	0.56
Personal Illness	31	33	0.06	0.80
Child Care	30	27	0.33	0.56
Transportation Difficulties	30	30	0.00	1.00
Housing	25	27	0.11	0.73
Mental Health	25	24	0.09	0.76
Child School	24	24	0.00	1.00
Working Overtime	22	30	2.78	0.09
Too Low Pay	21	30	3.00	0.08

TABLE II
Types of Discrimination (n=67)

Areas of Discrimination	T ₁ (%)	T ₂ (%)	χ^2	p
Racial	39	28	4.45	0.03
Cultural	34	22	4.57	0.03
Language	16	12	1.00	0.31
Social	12	18	2.67	0.10
Sexual	12	9	0.50	0.47
Family Status	8	16	6.00	0.01
Marital Status	6	9	1.00	0.31
Sexual Preference	2	8	4.00	0.45

TABLE III
Signs and Symptoms of Stress (n=67)

Signs and Symptoms of Stress	T ₁ (%)	T ₂ (%)	χ^2	p
Headaches	69	74	1.00	0.31
Anger	53	51	0.06	0.80
Fatigue	52	62	4.00	0.04
Insomnia	38	35	0.06	0.80
Overeating	27	25	0.11	0.73
Loss of Appetite	27	37	3.27	0.07
Agitation	19	23	0.82	0.36

TABLE IV
Stress Management Strategies (n=67)

Strategies to Manage Stress	T ₁ (%)	T ₂ (%)	χ^2	p
Prayer	64	58	1.00	0.31
Listen to Music	55	51	0.25	0.61
Hot Bath	42	48	1.00	0.31
Exercise	41	37	0.29	0.59
Reading	41	39	0.09	0.76
Positive Affirmation	39	39	0.00	1.00
Meditation	27	36	3.60	0.05
Contemplation	20	31	5.33	0.02
Good Nutrition	17	19	0.33	0.56

believed they had adequate access to health care and did not find language, discrimination, fear or being unknowledgeable regarding accessibility to be barriers.

The percentage of women experiencing stress related to finances, income and family remained high after the focus groups (Table I). Perceived discrimination was

reduced from 40% to 31% ($p=0.05$). Those who gained employment during the time of the workshops ($N=3$) indicated that family increased as a source of stress while financial stress decreased, although this was not statistically significant.

Racial, cultural, linguistic, social, and sexual areas were the predominant types of discrimination (Table II). Three areas of perceived discrimination decreased: racial ($p=0.03$), cultural ($p=0.03$) and family status ($p=0.01$) at T₂ (Table II). Perceived discrimination decreased from 60% (T₁) to 51% (T₂). The workshops emphasized that one does not have control over another person's perceptions; rather, that one should focus on one's own personal strengths and think positively.

The women identified signs and symptoms of stress in four areas: headaches (68%), anger (53%), fatigue (52%) and insomnia (38%). During focus groups facilitators observed participants begin to examine themselves critically and recognize their own responses to stress. Participants felt more comfortable expressing themselves. At T₂ they realized that loss of appetite and agitation were also clinical manifestations of stress. Participants were able to identify signs and symptoms of stress, as reflected in the wider distribution of responses (Table III).

Before and after the focus groups, women indicated the five highest-ranking stress management strategies to be prayer (64%), listening to music (55%), hot bath (42%), exercise and reading (41%) and positive affirmations (40%). Contemplation and meditation were found to increase at a statistically significant level at T₂ (Table IV).

The most influential factor in decreasing stress levels at both T₁ and T₂ was "family support" as identified by 76% of the participants. A notable change occurred with regard to child care arrangements with an increase from 18% (T₁) to 26% (T₂) having adequate arrangements ($p=0.01$). Family was shown to be a major source of support and understanding for working women.

At the onset of focus groups (T₁), participants were quiet and uncomfortable expressing their feelings, using non-verbal expressions such as smiling and head nod-

ding. Increasingly they became more verbal and supported each other's feelings and were comfortable expressing dissatisfactions, realizing their lack of awareness of clinical manifestations and sources of stress.

Participants realized the value of support groups and group process with women of their own ethnicity. The women gained an understanding of their daily stressors as caused by their multiple roles and conflict between Canadian and traditional cultural values.

DISCUSSION

This study reconfirmed previous findings that immigrant women have low income, lack support, are isolated and are discriminated against in the workplace. Women in this study felt that they were being discriminated against because of culture and race which are primary stressors in their lives. As perceived discrimination decreased, it is hypothesized that during the workshops, the women felt more comfortable expressing their feelings and were encouraged to take control of their environment while increasing their personal self-respect and confidence. This was in conjunction with the workshop objectives. Many of these women met others to whom they felt they could turn for support. Several groups verbalized the desire to continue meeting after the completion of the study.

As English was spoken as a first language by only 34% of the participants, language barriers were also reported as being stress inducing. This is understandable as language barriers often create conflict due to misunderstandings.

The fact that 97% of the participants believed they had adequate access to health care and did not find language, discrimination, fear, or being unknowledgeable regarding accessibility to be barriers was surprising and contrary to the literature.³⁷⁻³⁹

The increase in adequate child care arrangements ($p=0.01$) was thought to be a positive outcome as this is known to decrease workplace stress.⁴⁰ It appeared that family acted as a buffer to pressures experienced at work although there is still much research to be done in the area of stress-buffering mechanisms.⁴¹

The most prominent methods of stress management, contemplation and meditation, increased. It would appear that the women began looking inward for their own strength, which was consistent with workshop objectives and was something that women could integrate into their daily lives. These techniques of stress management have been used by other groups.¹⁸

Educational programs in mainstream and non-mainstream populations are therefore vital in decreasing societal conflict and creating healthy relationships among all races, particularly those with low socioeconomic status. Evidence shows that low socioeconomic status, lack of social support, and isolation are contributing factors to ill mental and physical health.^{4,42} As these factors are commonly experienced by ethnic minority women, the latter may be considered a high risk population.

To ensure the health and well-being of this population, health care professionals need to assess stress management techniques on an individual basis. The stress management techniques utilized in this study are not necessarily representative of ethnic minority women as a whole as focus group representation was not stratified with the Canadian population. However, it is felt that this particular group of women was coping with stressors and issues common to many Canadian ethnic minorities.¹ The findings are relevant to health care professionals in terms of their understanding of the unique issues facing ethnic minority women and the means by which they may facilitate healthy coping. The health care professional can assist the client in identifying stress-causing situations and manifestations; they need to help clients capitalize on existing healthy stress management techniques. By encouraging this self-reflection, health care professionals assist these women by facilitating greater self-respect, confidence and personal control.

ACKNOWLEDGEMENTS

The authors thank Shelley O'Neal and Jackie Roberts for their contribution to this paper.

REFERENCES

1. The Women's Health Bureau. Immigrant, Refugee and Racial Minority Women and Health Care Needs: Report of Community Consultations. Toronto: Ministry of Health, 1993.
2. Statistics Canada. Labour Force Survey. Ottawa: Bureau of Statistics, 1992.
3. Statistics Canada. Labour Force Survey. Ottawa: Bureau of Statistics, 1992.
4. Mustard JF, Frank J. The Determinants of Health. Toronto: Canadian Institute for Advanced Research, Population Health Program, 1991.
5. Canadian Mental Health Association Citizen's Survey Project Committee. Work and Well-Being: The Changing Realities of Employment. A Popular Summary, 1984.
6. Baker C, Arseneault AM, Gallant G. Resettlement without the support of an ethnocultural community. *J Adv Nurs* 1994;20:1064-72.
7. Lipson J. Afghan refugee health: Some findings and suggestions. *Qualitative Health Res* 1991;1(3):349-69.
8. Lipson J. The health and adjustment of Iranian immigrants. *Western J Nurs Res* 1992;14(1):10-29.
9. Overholser JC, Norman WH, Miller IW. Life stress and social supports in depressed inpatients. *Behav Med* 1990;16:125-32.
10. Beisner M. The mental health of immigrants and refugees in Canada. *Sante Culture Health* 1988;5(2):197-213.
11. Sundquist J. Ethnicity as a risk factor for mental illness. *Acta Psychiatr Scand* 1993;87(3):208-12.
12. Graham H. Women, Health and the Family. London: Health Education Council, 1984.
13. Broom G, Harris T. *The Social Origins of Depression: A Study of Psychiatric Disorder in Women*. London: Tavistock, 1978.
14. Bagley SP, Angel R, Diworth-Anderson P, et al. Panel V: Adaptive health behaviors among ethnic minorities. *Health Psychol* 1995;7:632-40.
15. Sundquist J. Ethnicity, social class and health. A population-based study on the influence of social factors on self-reported illness in 223 Latin American refugees, 333 Finnish and 126 south European labour migrants and 841 Swedish controls. *Soc Sci Med* 1995;40:777-87.
16. Franks F, Faux SA. Depression, stress and mastery and social resources in four ethnocultural women's groups. *Res Nurs Health* 1990;13(5):283-92.
17. McKinnon AL. Impacts of work and family responsibilities on the health of female municipal employees in the Hamilton region: A brief summary of findings. In: Edwards R (Ed.), *Women's Health Office Newsletter*. Hamilton, Ontario: McMaster University, May 1995.
18. Koch PB, Boose L, Cohn MD, et al. Coping strategies of traditionally and non-traditionally employed women at home and at work. *Health Values* 1991;15(1):19-31.
19. Gruber JE, Bjorn L. Blue-collar blues: The sexual harassment of women autoworkers. *Work and Occupations* 1982;9(3):271-98.
20. Kanter RM. *Men and Women of the Corporation*. New York: Basic Books, 1977.
21. Meyer H, Lee M. Women in traditionally male jobs: The experience of ten public utility companies. R and D Monograph 65, Washington, D.C.: U.S. Department of Labour, E.T.A., 1978.
22. Lee RPL. Traditional reaction to modern stress (Editorial). *Soc Sci Med* 1996;5:639-41.
23. Morgan DL. Why things (sometimes) go wrong in focus groups. *Qualitative Health Res* 1995;5(4):516-23.

24. Asbury J-E. Overview of focus group research. *Qualitative Health Res* 1995;5(4):414-20.
25. Carey MA. Concerns in the analysis of focus group data (Comment). *Qualitative Health Res* 1995;5(4):487-95.
26. Stewart DW, Shamdasani PN. Conducting the focus group. *Focus Groups: Theory and Practice*. London: Sage Publications, 1990; 87-121.
27. Krueger RA. The future of focus groups. *Qualitative Health Res* 1995;5(4):524-30.
28. Smith MW. Ethics in focus groups: A few concerns. *Qualitative Health Res* 1995;5(4):478-86.
29. McDaniel RW, Bach CA. Focus groups: A data-gathering strategy for nursing research. *Nurs Sci Q* 1994;7(1):4-5.
30. Stevens PE. Focus groups: Collecting aggregation level data to understand community health phenomena. *Public Health Nurs* 1996;13(3):170-76.
31. Levenstein S, Prantera C, Varvo V, et al. Development of the perceived stress questionnaire: A new tool for psychosomatic research. *J Psychosom Res* 1993;37(1):19-32.
32. Brantley PJ, Waggoner CD, Jones GN, Rappaport NB. A daily stress inventory: Development, reliability, and validity. *J Behav Med* 1987;10(1):61-74.
33. McDowell I, Newell C. *Measuring Health: A Guide to Rating Scales and Questionnaires*. New York, Oxford: Oxford University Press, 1987.
34. Cohen S, Kamarack T, Mermelstein R. A global measure of perceived stress. *J Health Soc Behav* 1983;24(4):385-96.
35. Spielberger CD, Gorsuch RL, Luchene R. *Manual for the State-Trait Anxiety Inventory*. (Self evaluation questionnaire). Palo Alto, CA: Consulting Psychologists Press, 1970.
36. Nakagawa-Kogan H. *Symptoms of Stress Inventory*. Washington, DC: Management of Stress Response Clinic, 1976.
37. The Women's Health Bureau. Ministry of Health Ontario. Immigrant, Refugee and Racial Minority Women and Health Care Needs, 1993.
38. Majumdar B, Browne G, Roberts J. The prevalence of multicultural groups receiving in-home service from three community agencies in Southern Ontario: Implications for cultural sensitivity training. *Can J Public Health* 1995;86(3):206-11.
39. Carlisle DM, Leake BD, Shapiro MF. Racial and ethnic differences in the use of invasive procedures among cardiac patients in Los Angeles county 1986-1988. *Am J Public Health* 1995;85(3):352-56.
40. Freedman SM, Bisesi M. Women and workplace stress. *AAOHN J* 1988;36(6):271-75.
41. Kong F, Perucci CC, Perucci R. The impact of unemployment and economic stress on social support. *Community Ment Health J* 1993;29(3):205-21.
42. Beiser M, Turner RJ, Ganesan S. Catastrophic stress and factors affecting its consequences among southeast Asian refugees. In: *After the Door Has Been Opened. Mental Health Issues Affecting Immigrants and Refugees in Canada*. Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988.

Received: September 4, 1996

Accepted: September 29, 1997